IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

METROPOLITAN LIFE INSURANCE COMPANY, Plaintiff, v. ROBYN SMITH, LORENZO MARCHELL, REBECCA WELCH, as executor of the ESTAND OF CLARENCE MARCHELL, Defendants.	)	No.

FILED: JUNE 9, 2008
08CV3336
JUDGE KOCORAS
MAGISTRATE JUDGE BROWN
TG

COMPLAINT FOR INTERPLEADER

Plaintiff Metropolitan Life Insurance Company ("MetLife"), for its Complaint for Interpleader against defendants Robyn Smith, Lorenzo Marchell, and Rebecca Welch, as the executor of the Estate of Clarence Marchell (collectively, "Defendants"), states as follows:

PARTIES

1. MetLife is a corporation organized and existing under the laws of the State of New York with its principal place of business in New York. MetLife is duly licensed to do business in the State of Illinois.

2. Upon information and belief, Defendant Robyn Smith ("Ms. Smith") was the fiancé of Clarence Marchell (the "Decedent") and is a resident and citizen of Bloomington, McLean County, Illinois.

3. Upon information and belief, Defendant Lorenzo Marchell ("Mr. Marchell") is the son of the Decedent and is a resident and citizen of Richton Park, Cook County, Illinois.

4. Upon information and belief, Defendant Rebecca Welch ("Ms. Welch") is the Decedent's sister and executor of his estate and is a resident and citizen of Bloomington, McLean County, Illinois.

JURISDICTION AND VENUE

5. This court has subject matter jurisdiction over this action pursuant to Fed. R. Civ. P. 22 and 28 U.S.C. § 1331 in that this matter arises under federal law because it involves an employee welfare benefit plan regulated by the Employee Retirement Income Security Act of 1974, as amended, 29 U.S.C. §§ 1001, *et seq.* ("ERISA"). This Court's original jurisdiction therefore is founded upon 29 U.S.C. § 1132(e)(1).

6. Venue is proper in the Northern District of Illinois pursuant to 28 U.S.C. § 1391(b) (the district where any defendant resides). *See also* 29 U.S.C. § 1132(e)(2).

CAUSE OF ACTION IN INTERPLEADER

7. This is an action for interpleader based on competing claims for life insurance benefits.

8. MetLife issued a group life insurance policy to Bridgestone Americas Holding, Inc., to fund the Bridgestone Basic Life Insurance Plan (the "Plan"). The Plan is an employee welfare benefit plan subject to and governed by the provisions of ERISA. A true and correct copy of the applicable Certificate of Insurance is attached hereto as Exhibit A.

9. The Decedent, who was a resident of Bloomington, McLean County, Illinois, died on May 24, 2007. A true and correct copy of the Decedent's Certificate of Death is attached hereto as Exhibit B.[1]

[1] Where applicable, social security numbers have been redacted.

10. At the time of his death, the Decedent, who had been an employee of Bridgestone Americas Holding, Inc., was a participant in the Plan, and was enrolled for basic life insurance benefits in the amount of $45,000, plus any applicable interest (the "Plan Benefits").

11. As a result of his death, the Plan Benefits became payable in accordance with the terms of the Plan.

12. The Plan states that the employee:

> may designate a Beneficiary in [his] application or enrollment form. [He] may change [his] Beneficiary at any time. To do so, [he] must send a Signed and dated, Written request to the Policyholder using a form satisfactory to [MetLife]. [His] Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date [he] Sign[s] such request ... If there is no Beneficiary designated or no surviving Beneficiary at [his] death, [MetLife] may determine the Beneficiary to be one or more of the following who survive [him]:
>
> 1. [His] spouse;
> 2. [His] child(ren);
> 3. [His] parent(s); or
> 4. [His] sibling(s).
>
> Instead of making payment to any of the above, [MetLife] may pay [his] estate. Any payment made in good faith will discharge [MetLife's] liability to the extent of such payment. (Exhibit A at 39.)

13. ERISA defines a beneficiary as "[a] person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8).

14. On or about November 9, 2000, the Decedent designated Ms. Smith as the sole primary beneficiary of the Plan Benefits. A true and correct copy of the November 9, 2000 beneficiary designation form is attached hereto as Exhibit C.

15. On or about May 23, 2007, the Decedent executed a beneficiary designation form designating himself as the sole beneficiary of the Plan Benefits. A true and correct copy of the May 23, 2007 beneficiary designation form is attached hereto as Exhibit D.

16. Mr. Marchell filed a claim for the Plan Benefits based on the Plan's facility of payment provision as if the May 23, 2007 beneficiary designation form was valid, and as if it was the Decedent's intent to name himself, but because the Decedent could not receive the Plan Benefits upon his death, under the facility of payment provision, Mr. Marchell was next in line as the only surviving child of the Decedent to receive the Plan Benefits.

17. Ms. Smith filed a claim for Plan Benefits based on the November 9, 2000 beneficiary designation form and questioning the validity of the May 23, 2007 beneficiary designation form on file, specifically by letter dated June 15, 2007, her attorney, informed MetLife that the Decedent may have been of unsound mind and lacked the capacity to understand the purpose and effect of the change of beneficiary when he signed the May 23, 2007 beneficiary designation form in the hours preceding his death. A true and correct copy of the June 15, 2007 letter is attached hereto as Exhibit E.

18. MetLife cannot determine the validity of the May 23, 2007 beneficiary designation form or the Decedent's mental capacity to designate a beneficiary. Further, if the May 23, 2007 beneficiary designation form is valid, MetLife cannot determine if it was the Decedent's intent to name his estate as the sole beneficiary on this form when he designated himself.

19. MetLife is ready, willing and able to pay the Plan Benefits that are payable as a consequence of the death of the Decedent, and MetLife is prepared to pay immediately the Plan Benefits into the Registry of this Court, or as this Court otherwise directs.

20. MetLife is a mere stakeholder, has no interest in the Plan Benefits payable, and respectfully requests that this Court determine to whom the Plan Benefits should be paid.

21. MetLife will deposit into the Registry of the Court the Plan Benefits, that is due and owing in accordance with the terms of the Plan for disbursement in accordance with the judgment of this Court.

22. MetLife has not brought this Complaint for Interpleader at the request of any or all of the claimants; there is no fraud or collusion between MetLife and any or all of the claimants; and MetLife brings this Complaint for Interpleader of its own free will and to avoid being vexed and harassed by conflicting and multiple claims.

23. Until this Court rules on the issue of whether the May 23, 2007 beneficiary designation form is valid, and if so, whether the Decedent intended to name his estate as the beneficiary of the Plan Benefits, MetLife cannot safely determine the beneficiary of the Plan Benefits without risking exposure to double liability.

WHEREFORE, Plaintiff Metropolitan Life Insurance Company respectfully requests this Court to enter judgment against Defendants as follows:

A. Restraining and enjoining Defendants by Order and Injunction of this Court from instituting any proceeding or action against MetLife, Bridgestone Americas Holding, Inc., or the Plan for the recovery of Plan Benefits, or their attorneys relating to Plan Benefits involved in this interpleader action, or any attorney's lien relating to Plan Benefits, and said injunction shall be without bond or surety;

B. Requiring Defendants to answer this Complaint for Interpleader;

C. Requiring that Defendants settle and adjust among themselves or, upon failure to do so, the entry of an order of this Court declaring to whom the Plan Benefits should be paid;

D. Permitting MetLife to deposit the Plan Benefits, into the Registry of this Court or as this Court otherwise directs, subject to further order of this Court;

E. Dismissing MetLife with prejudice from this action, and discharging MetLife, Bridgestone Americas Holding, Inc., and the Plan from any further

liability upon deposit of the Plan Benefits into the Registry of this Court or as otherwise directed by this Court;

F. Awarding MetLife its costs and reasonable attorneys' fees, to be deducted from the Plan Benefits deposited with the Registry of this Court; and

G. Awarding MetLife any other and further relief that this Court deems just and proper.

Respectfully submitted,

METROPOLITAN LIFE INSURANCE COMPANY

Dated: June 9, 2008

By: /s/ Brendan J. Healey
One of Its Attorneys

Steven P. Mandell (ARDC No. 6183729)
Brendan J. Healey (ARDC No. 6243091)
Lindsay H. LaVine (ARDC No. 6291725)
Mandell Menkes LLC
333 West Wacker Drive
Suite 300
Chicago, Illinois 60606
(312) 251-1000

JUDGE KOCORAS
MAGISTRATE JUDGE BROWN
TG

EXHIBIT A

YOUR BENEFIT PLAN

Bridgestone Americas Holding, Inc.

Basic Life Insurance

Accidental Death and Dismemberment Insurance

Class 10 All active, Full-Time Employees of the Orange Plant

January 1, 2006

Bridgestone Americas Holding, Inc
1200 Firestone Parkway
Akron, OH 44317-0001

TO OUR EMPLOYEES:

All of us appreciate the protection and security insurance provides

This certificate describes the benefits that are available to you We urge you to read it carefully

Bridgestone Americas Holding, Inc

MetLife®

Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

CERTIFICATE OF INSURANCE

Metropolitan Life Insurance Company ("MetLife"), a stock company, certifies that You are insured for the benefits described in this certificate, subject to the provisions of this certificate. This certificate is issued to You under the Group Policy and it includes the terms and provisions of the Group Policy that describe Your insurance. **PLEASE READ THIS CERTIFICATE CAREFULLY.**

This certificate is part of the Group Policy. The Group Policy is a contract between MetLife and the Policyholder and may be changed or ended without Your consent or notice to You.

Policyholder:	Bridgestone Americas Holding, Inc
Group Policy Number:	93433-1-G
Type of Insurance:	Term Life & Accidental Death and Dismemberment Insurance
MetLife Toll Free Number(s): For Claim Information	FOR LIFE CLAIMS: 1-800-638-6420

THIS CERTIFICATE ONLY DESCRIBES LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE.

THE BENEFITS OF THE POLICY PROVIDING YOU COVERAGE ARE GOVERNED PRIMARILY BY THE LAWS OF A STATE OTHER THAN FLORIDA.

THE GROUP INSURANCE POLICY PROVIDING COVERAGE UNDER THIS CERTIFICATE WAS ISSUED IN A JURISDICTION OTHER THAN MARYLAND AND MAY NOT PROVIDE ALL THE BENEFITS REQUIRED BY MARYLAND LAW.

For Residents of North Dakota: If you are not satisfied with your Certificate, You may return it to Us within 20 days after You receive it, unless a claim has previously been received by Us under Your Certificate. We will refund within 30 days of our receipt of the returned Certificate any Premium that has been paid and the Certificate will then be considered to have never been issued. You should be aware that, if you elect to return the Certificate for a refund of premiums, losses which otherwise would have been covered under your Certificate will not be covered.

WE ARE REQUIRED BY STATE LAW TO INCLUDE THE NOTICE(S) WHICH APPEAR ON THIS PAGE AND IN THE NOTICE(S) SECTION WHICH FOLLOWS THIS PAGE. PLEASE READ THE(SE) NOTICE(S) CAREFULLY.

For Texas Residents:

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MetLife's toll free telephone number for information or to make a complaint at

1-800-638-6420

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at

1-800-252-3439

You may write the Texas Department of Insurance

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

PREMIUM OR CLAIM DISPUTES: Should You have a dispute concerning Your premium or about a claim, You should contact MetLife first. If the dispute is not resolved, You may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR CERTIFICATE: This notice is for information only and does not become a part or condition of the attached document

Para Residentes de Texas:

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de MetLife para informacion o para someter una queja al

1-800-638-6420

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas

P.O. Box 149104
Austin, TX 78714-9104
Fax # (512) 475-1771

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con MetLife primero Si no se resuelve la disputa, puede entonces comunicarse con el departamento (TDI)

UNA ESTE AVISO A SU CERTIFICADO: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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NOTICE FOR RESIDENTS OF ALL STATES

LIFE INSURANCE BENEFITS WILL BE REDUCED IF AN ACCELERATED BENEFIT IS PAID

DISCLOSURE: The Life Insurance accelerated benefit offered under this certificate is intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. If this benefit qualifies for such favorable tax treatment, the benefit will be excludable from Your income and not subject to federal taxation. Tax laws relating to accelerated benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which You could receive an accelerated benefit excludable from income under federal law

DISCLOSURE: Receipt of an accelerated benefit may affect Your, Your Spouse's or Your family's eligibility for public assistance programs such as Medical Assistance (Medicaid), Aid to Families with Dependent Children (AFDC), Supplementary Social Security Income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such payment will affect Your, Your Spouse's and Your family's eligibility for public assistance

NOTICE FOR RESIDENTS OF ARKANSAS

If You have a question concerning Your coverage or a claim, first contact the Policyholder or group account administrator. If, after doing so, You still have a concern, You may call the toll free telephone number shown on the Certificate Face Page

If You are still concerned after contacting both the Policyholder and MetLife, You should feel free to contact:

Arkansas Insurance Department
Consumer Services Division
1200 West Third
Little Rock, Arkansas 72204-1904
1-800-852-5494

NOTICE FOR RESIDENTS OF CALIFORNIA

IMPORTANT NOTICE

TO OBTAIN ADDITIONAL INFORMATION, OR TO MAKE A COMPLAINT, CONTACT THE POLICYHOLDER OR THE METLIFE CLAIM OFFICE SHOWN ON THE EXPLANATION OF BENEFITS YOU RECEIVE AFTER FILING A CLAIM.

IF, AFTER CONTACTING THE POLICYHOLDER AND/OR METLIFE, YOU FEEL THAT A SATISFACTORY SOLUTION HAS NOT BEEN REACHED, YOU MAY FILE A COMPLAINT WITH THE CALIFORNIA INSURANCE DEPARTMENT AT:

DEPARTMENT OF INSURANCE
300 SOUTH SPRING STREET
LOS ANGELES, CA 90013
1 (800) 927-4357

CIVIL UNION NOTICE FOR RESIDENTS OF CONNECTICUT

Connecticut law provides that the following definition applies to Your certificate:

'Civil Union' means a civil union established pursuant to Pub. Act No. 05-10 Connecticut Legislative Session, entitled 'An Act Concerning Civil Unions'.

Connecticut law provides that:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as 'marriage,' 'spouse,' 'dependent,' 'relative,' 'beneficiary,' 'survivor,' 'immediate family', include the relationship created by a Civil Union.
- Terms that mean or refer to the inception or dissolution of a marriage, such as 'divorce decree,' include the inception or dissolution of a Civil Union

NOTICE FOR RESIDENTS OF GEORGIA

IMPORTANT NOTICE

The laws of the state of Georgia prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

NOTICE FOR RESIDENTS OF ILLINOIS

IMPORTANT NOTICE

To make a complaint to MetLife, You may write to:

MetLife
200 Park Avenue
New York, New York 10166

The address of the Illinois Department of Insurance is:

Illinois Department of Insurance
Public Services Division
Springfield, Illinois 62767

NOTICE FOR MASSACHUSETTS RESIDENTS

CONTINUATION OF ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

1. If Your AD&D Insurance ends due to a Plant Closing or Covered Partial Closing, such insurance will be continued for 90 days after the date it ends

2. If Your AD&D Insurance ends because:

   - You cease to be in an Eligible Class; or
   - Your employment terminates;

for any reason other than a Plant Closing or Covered Partial Closing, such insurance will continue for 31 days after the date it ends

Continuation of Your AD&D Insurance under the CONTINUATION WITH PREMIUM PAYMENT subsection will end before the end of continuation periods shown above if You become covered for similar benefits under another plan

Plant Closing and **Covered Partial Closing** have the meaning set forth in Massachusetts Annotated Laws, Chapter 151A, Section 71A.

NOTICE FOR RESIDENTS OF MINNESOTA

This is a life insurance policy which pays accelerated death benefits at your option under conditions specified in the policy. This policy is not a long-term care policy meeting the requirements of sections M.S.62A 46 to 62A.56 or chapter 62S.

NOTICE FOR RESIDENTS OF NORTH CAROLINA

Read your Certificate Carefully.

IMPORTANT CANCELLATION INFORMATION

Please Read The Provision Entitled

DATE YOUR INSURANCE ENDS

Found on Pages e/ee

NOTICE TO POLICYHOLDERS

Insurance companies licensed to sell life insurance, health insurance, or annuities in the State of Utah are required by law to be members of an organization called the Utah Life and Health Insurance Guaranty Association ("ULHIGA"). If an insurance company that is licensed to sell insurance in Utah becomes insolvent (bankrupt), and is unable to pay claims to its policyholders, the law requires ULHIGA to pay some of the insurance company's claims. The purpose of this notice is to briefly describe some of the benefits and limitations provided to Utah insureds by ULHIGA.

PEOPLE ENTITLED TO COVERAGE

- You must be a Utah resident.
- You must have insurance coverage under an individual or group policy.

POLICIES COVERED

- ULHIGA provides coverage for certain life, health and annuity insurance policies.

EXCLUSIONS AND LIMITATIONS

Several kinds of insurance policies are specifically excluded from coverage. There are also a number of limitations to coverage. The following are not covered by ULHIGA:

- Coverage through an HMO.
- Coverage by insurance companies not licensed in Utah.
- Self-funded and self-insured coverage provided by an employer that is only administered by an insurance company.
- Policies protected by another state's Guaranty Association.
- Policies where the insurance company does not guarantee the benefits.
- Policies where the policyholder bears the risk under the policy.
- Re-insurance contracts.
- Annuity policies that are not issued to and owned by an individual, unless the annuity policy is issued to a pension benefit plan that is covered.
- Policies issued to pension benefit plans protected by the Federal Pension Benefit Guaranty Corporation.
- Policies issued to entities that are not members of the ULHIGA, including health plans, fraternal benefit societies, state pooling plans and mutual assessment companies.

LIMITS ON AMOUNT OF COVERAGE

Caps are placed on the amount ULHIGA will pay. These caps apply even if you are insured by more than one policy issued by the insolvent company. The maximum ULHIGA will pay is the amount of your coverage or $500,000 — whichever is lower. Other caps also apply:

- $100,000 in net cash surrender values

- $500,000 in life insurance death benefits (including cash surrender values).
- $500,000 in health insurance benefits.
- $200,000 in annuity benefits — if the annuity is issued to and owned by an individual or the annuity is issued to a pension plan covering government employees.
- $5,000,000 in annuity benefits to the contract holder of annuities issued to pension plans covered by the law. (Other limitations apply).
- Interest rates on some policies may be adjusted downward.

DISCLAIMER

PLEASE READ CAREFULLY:

COVERAGE FROM ULHIGA MAY BE UNAVAILABLE UNDER THIS POLICY. OR, IF AVAILABLE, IT MAY BE SUBJECT TO SUBSTANTIAL LIMITATIONS OR EXCLUSIONS. THE DESCRIPTION OF COVERAGES CONTAINED IN THIS DOCUMENT IS AN OVERVIEW. IT IS NOT A COMPLETE DESCRIPTION. YOU CANNOT RELY ON THIS DOCUMENT AS A DESCRIPTION OF COVERAGE. FOR A COMPLETE DESCRIPTION OF COVERAGE, CONSULT THE UTAH CODE, TITLE 31A, CHAPTER 28.

COVERAGE IS CONDITIONED ON CONTINUED RESIDENCY IN THE STATE OF UTAH.

THE PROTECTION THAT MAY BE PROVIDED BY ULHIGA IS NOT A SUBSTITUTE FOR CONSUMERS' CARE IN SELECTING AN INSURANCE COMPANY THAT IS WELL-MANAGED AND FINANCIALLY STABLE.

INSURANCE COMPANIES AND INSURANCE AGENTS ARE REQUIRED BY LAW TO GIVE YOU THIS NOTICE. THE LAW DOES, HOWEVER, PROHIBIT THEM FROM USING THE EXISTENCE OF ULDIGA AS AN INDUCEMENT TO SELL YOU INSURANCE.

THE ADDRESS OF ULHIGA, AND THE INSURANCE DEPARTMENT ARE PROVIDED BELOW.

Utah Life and Health Insurance
Guaranty Association
955 E Pioneer Rd.
Draper, Utah 84114

Utah Insurance Department
State Office Building, Room 3110
Salt Lake City, Utah 84114

Vermont law provides that the following definitions apply to Your certificate:

- Terms that mean or refer to a marital relationship, or that may be construed to mean or refer to a marital relationship, such as "marriage," "spouse," "husband," "wife," "dependent," "next of kin," "relative," "beneficiary," "survivor," "immediate family" and any other such terms include the relationship created by a Civil Union established according to Vermont law.

- Terms that mean or refer to the inception or dissolution of a marriage, such as "date of marriage," "divorce decree," "termination of marriage" and any other such terms include the inception or dissolution of a Civil Union established according to Vermont law.

- Terms that mean or refer to family relationships arising from a marriage, such as "family," "immediate family," "dependent," "children," "next of kin," "relative." "beneficiary," "survivor" and any other such terms include family relationships created by a Civil Union established according to Vermont law

- "Dependent" includes a spouse, a party to a Civil Union established according to Vermont law, and a child or children (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Child" includes a child (natural, stepchild, legally adopted or a minor or disabled child who is dependent on the insured for support and maintenance) who is born to or brought to a marriage or to a Civil Union established according to Vermont law.

- "Civil Union" means a civil union established pursuant to Act 91 of the 2000 Vermont Legislative Session, entitled "Act Relating to Civil Unions"

All references in this notice to Civil Unions are limited to Civil Unions in which the parties are residents of Vermont.

If dependent insurance for a spouse and/or child is not provided under Your certificate, such insurance is not added by virtue of this notice.

For purposes of dependent insurance. any person who meets the definition of "dependent" as set forth in this notice is required to meet all other applicable requirements in order to qualify for such insurance

This notice does not limit any definitions or terms included in Your certificate. It broadens definitions and terms only to the extent required by Vermont law

DISCLOSURE:

Vermont law grants parties to a Civil Union the same benefits, protections and responsibilities that flow from marriage under state law. However, some or all of the benefits, protections and responsibilities related to life and health insurance that are available to married persons under federal law may not be available to parties to a Civil Union. For example, a federal law, the Employee Retirement Income Security Act of 1974 known as "ERISA", controls the employer/employee relationship with regard to determining eligibility for enrollment in private employer benefit plans. Because of ERISA, Act 91 does not state requirements pertaining to a private employer's enrollment of a party to a Civil Union in an ERISA employee benefit plan. However, governmental employers (not federal government) are required to provide life and health benefits to the dependents of a party to a Civil Union if the public employer provides such benefits to dependents of married persons. Federal law also controls group health insurance continuation rights under "COBRA" for employers with 20 or more employees as well as the Internal Revenue Code treatment of insurance premiums. As a result, parties to a Civil Union and their families may or may not have access to certain benefits under this notice and the certificate to which it is attached that derive from federal law. You are advised to seek expert advice to determine Your rights under this notice and the certificate to which it is attached.

FOR RESIDENTS OF VIRGINIA

IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

MetLife
200 Park Avenue
New York, New York 10166
Attn: Corporate Customer Relations Department

To phone in a claim related question, You may call Claims Customer Service at:
1-800-275-4638

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact the Virginia State Corporation Commission's Bureau of Insurance at:

The Office of the Managed Care Ombudsman
Bureau of Insurance
P O. Box 1157
Richmond, VA 23209
1-800-552-7945 - In-state toll-free
1-804-371-9691 - Out-of-state

Or:

The Virginia Department of Health (The Center for Quality Health Care Services and Consumer Protection)
3600 West Broad St
Suite 216
Richmond, VA 23230
1-800-955-1819

Written correspondence is preferable so that a record of Your inquiry is maintained When contacting Your agent, company or the Bureau of Insurance. have Your policy number available

NOTICE FOR RESIDENTS OF WISCONSIN

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? - If You are having problems with Your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve Your problem.

MetLife
Attn: Corporate Consumer Relations Department
200 Park Avenue
New York, NY 10166-0188
1-800-638-5433

You can also contact the **OFFICE OF THE COMMISSIONER OF INSURANCE**, a state agency which enforces Wisconsin's insurance laws, and file a complaint. You can contact the **OFFICE OF THE COMMISSIONER OF INSURANCE** by contacting:

Office of the Commissioner of Insurance
Complaints Department
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517 outside of Madison or 266-0103 in Madison

NOTICE FOR RESIDENTS OF ALL STATES
FRAUD WARNING

If You have applied for insurance under a policy issued in one of the following states, **or** if You reside in one of the following states, note the following applicable warning:

For Residents of New York - only applies to Accident and Health Insurance (AD&D/Disability/Dental)
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Florida
Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For Residents of Massachusetts
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, and may subject such person to criminal and civil penalties.

For Residents of New Jersey
Any person who includes any false or misleading information on an application for an insurance policy or who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

For Residents of Oklahoma
Any person who knowingly, and with intent to injure. defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony

For Residents of Kansas, Oregon, Washington and Vermont
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading. information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties

For Residents of Puerto Rico
Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5.000) dollars nor more than ten thousand (10.000), or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For Residents of Virginia
It is a crime to provide knowingly false. incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment. fines and denial of insurance benefits

For Residents of All Other States
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

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Section Page

This schedule shows the benefits that are available under the Group Policy You will only be insured for the benefits:

- for which You become and remain eligible;
- which You elect, if subject to election; and
- which are in effect.

BENEFIT	BENEFIT AMOUNTS AND HIGHLIGHTS

Life Insurance For You

For Active Employees	$30,000
Accelerated Benefit Option	Up to 50% of Your Basic Life amount not to exceed $15,000
For Retired Employees	$20,000

Comment: Not in CIGNA

For Disabled Employees:

If You cease Active Work due to injury or sickness, Your Basic Life Insurance amount will be as recorded and maintained by the Policyholder and reported to us

Accidental Death and Dismemberment Insurance (AD&D) for You

Full Amount for AD&D

For Active Employees	An amount equal to Your Life Insurance

Additional Benefits:

Seat Belt Benefit	Yes

Schedule of Covered Losses for Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

Covered Losses

Loss of life	100%
Loss of a hand permanently severed at or above the wrist but below the elbow	50%
Loss of a foot permanently severed at or above the ankle but below the knee	50%

Loss of an arm permanently severed at or above the elbow	75%	Comment: Not in CIGNA
Loss of a leg permanently severed at or above the knee	75%	Comment: Not in CIGNA
Loss of sight in one eye	50%	

Loss of sight means permanent and uncorrectable loss of sight in the eye. Visual acuity must be 20/200 or worse in the eye or the field of vision must be less than 20 degrees

Loss of any combination of hand, foot, or sight of one eye, as defined above	100%
Loss of four fingers of same hand	50%
Loss of the thumb and index finger of same hand	25%

Loss of thumb and index finger of same hand means that the thumb and index finger are permanently severed through or above the third joint from the tip of the index finger and the second joint from the tip of the thumb.

Loss of speech and loss of hearing	100%
Loss of speech or loss of hearing	50%

Loss of speech means the entire and irrecoverable loss of speech that continues for 6 consecutive months following the accidental injury

Loss of hearing means the entire and irrecoverable loss of hearing in both ears that continues for 6 consecutive months following the accidental injury

Paralysis of both arms and both legs	100%
Paralysis of both legs	50%
Paralysis of the arm and leg on either side of the body	50%
Paralysis of one arm or leg	25%

Paralysis means loss of use of a limb, without severance. A Physician must determine the paralysis to be permanent, complete and irreversible.

DEFINITIONS

As used in this certificate, the terms listed below will have the meanings set forth below. When defined terms are used in this certificate, they will appear with initial capitalization. The plural use of a term defined in the singular will share the same meaning

Actively at Work or Active Work means that You are performing all of the usual and customary duties of Your job on a Full-Time basis. This must be done at:

- the Policyholder's place of business;
- an alternate place approved by the Policyholder; or
- a place to which the Policyholder's business requires You to travel

You will be deemed to be Actively at Work during weekends or Policyholder approved vacations, holidays or business closures if You were Actively at Work on the last scheduled work day preceding such time off

Beneficiary means the person(s) to whom We will pay insurance as determined in accordance with the GENERAL PROVISIONS section

Common Carrier means a government regulated entity that is in the business of transporting fare paying passengers.

The term does not include:

- chartered or other privately arranged transportation;
- taxis; or
- limousines

Full-Time means Active Work on the Policyholder's regular work schedule for the eligible class of employees to which You belong.

Noncontributory Insurance means insurance for which the Policyholder does not require You to pay any part of the premium

Physician means:

- a person licensed to practice medicine in the jurisdiction where such services are performed; or
- any other person whose services, according to applicable law, must be treated as Physician's services for purposes of the Group Policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction

The term does not include:

- You;
- Your Spouse; or
- any member of Your immediate family including Your and/or Your Spouse's:
  - parents;
  - children (natural, step or adopted);
  - siblings;
  - grandparents; or
  - grandchildren.

Proof means Written evidence satisfactory to Us that a person has satisfied the conditions and requirements for any benefit described in this certificate. When a claim is made for any benefit described in this certificate, Proof must establish:

- the nature and extent of the loss or condition;
- Our obligation to pay the claim; and
- the claimant's right to receive payment.

Proof must be provided at the claimant's expense.

Signed means any symbol or method executed or adopted by a person with the present intention to authenticate a record, which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

Spouse means Your lawful spouse.

We, Us and **Our** mean MetLife.

Written or **Writing** means a record which is on or transmitted by paper or electronic media which is acceptable to Us and consistent with applicable law.

You and **Your** mean an employee who is insured under the Group Policy for the insurance described in this certificate.

ELIGIBLE CLASS(ES)

Class 10 All active, Full-Time Employees of the Policyholder who work at the Orange Plant.

You are eligible for insurance if You were Actively at Work and covered for insurance on the day immediately preceding the date of Your retirement and have retired in accord with the Policyholder's retirement plan. Please be aware that:

- references to Active Work and Actively at Work will not apply; and
- end of employment will mean the end of the person's status as a retiree, as stated in the Policyholder's retirement plan

DATE YOU ARE ELIGIBLE FOR INSURANCE

You may only become eligible for the insurance available for Your eligible class as shown in the SCHEDULE OF BENEFITS

You will be eligible for insurance on the later of:

1. January 1, 2006; and

2. the day after the date You complete the Waiting Period that applies to such insurance

Waiting Period means the period of continuous membership in an eligible class that You must wait before You become eligible for insurance. This period begins on the date You enter an eligible class and ends on the date You complete the period(s) specified

The Waiting Periods in effect under the Group Policy are as follows:

Insurance Benefit	Waiting Period
Life Insurance	30 Days
Accidental Death and Dismemberment Insurance	30 Days

Previous Employment With The Policyholder

If You were employed by the Policyholder and insured by Us under a policy of group life insurance when Your employment ended, You will not be eligible for life insurance under this Group Policy if You are re-hired by the Policyholder within 2 years after such employment ended, unless You surrender any individual policy of life insurance to which You converted when Your employment ended

The cash value, if any, of such surrendered insurance will be paid to You

ELIGIBILITY PROVISIONS: INSURANCE FOR YOU (continued)

ENROLLMENT PROCESS

If You are eligible for Insurance, You may enroll for such insurance by completing an enrollment form

DATE YOUR INSURANCE TAKES EFFECT

Rules for Noncontributory Insurance

When You complete the enrollment process for Noncontributory Insurance, such insurance will take effect on the date You become eligible, provided You are Actively at Work on that date.

If You are not Actively at Work on the date the Noncontributory Insurance would otherwise take effect, the benefit will take effect on the day You resume Active Work

DATE YOUR INSURANCE ENDS

Your insurance will end on the earliest of:

1. the date the Group Policy ends; or
2. the date insurance ends for Your class; or
3. the end of the period for which the last premium has been paid for You; or
4. for Basic Life Insurance, the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
5. for Accidental Death and Dismemberment Insurance, the date Your employment ends; Your employment will end if You cease to be Actively at Work in any eligible class, except as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT; or
6. for Accidental Death and Dismemberment Insurance, the date You retire in accordance with the Policyholder's retirement plan

Please refer to the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU for information concerning the option to convert to an individual policy of life insurance if Your Life Insurance ends.

In certain cases insurance may be continued as stated in the section entitled CONTINUATION OF INSURANCE WITH PREMIUM PAYMENT

No evidence of insurability is required for the insurance described in this certificate.

LIFE INSURANCE: FOR YOU

If You die, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and, if We approve it, will pay the Beneficiary the Life Insurance in effect on the date of Your death.

PAYMENT OPTIONS

We will pay the Life Insurance in one sum. Other modes of payment may be available upon request. For details, call Our toll free number shown on the Certificate Face Page.

LIFE INSURANCE ACCELERATED BENEFIT OPTION (ABO) ENDORSED

For purposes of this section, the term "ABO Eligible Life Insurance" refers to each of Your Life Insurance benefits for which the Accelerated Benefit Option is shown as available in the SCHEDULE OF BENEFITS.

If You become Terminally Ill, You or Your legal representative have the option to request Us to pay ABO Eligible Life Insurance before Your death. This is called an accelerated benefit. The request must be made while ABO Eligible Life Insurance is in effect.

Terminally Ill or Terminal Illness means that due to injury or sickness, You are expected to die within 12 months.

Requirements For Payment of an Accelerated Benefit

Subject to the conditions and requirements of this section, We will pay an accelerated benefit to You or Your legal representative if:

- the amount of each ABO Eligible Life Insurance benefit to be accelerated equals or exceeds $10,000; and
- the ABO Eligible Life Insurance to be accelerated has not been assigned; and
- We have received Proof that You are Terminally Ill.

We will only pay an accelerated benefit for each ABO Eligible Life Insurance benefit once.

Proof of Your Terminal Illness

We will require the following Proof of Your Terminal Illness:

- a completed accelerated benefit claim form;
- a signed Physician's certification that You are Terminally Ill; and
- an examination by a Physician of Our choice, at Our expense, if We request it.

You or Your legal representative should contact the Policyholder to obtain a claim form and information regarding the accelerated benefit.

Upon Our receipt of Your request to accelerate benefits, We will send You a letter with information about the accelerated benefit payment You requested. Our letter will describe the amount of the accelerated benefits We will pay and the amount of Life Insurance remaining after the accelerated benefit is paid.

Accelerated Benefit Amount

We will pay an accelerated benefit up to the percentage shown in the SCHEDULE OF BENEFITS for each ABO Eligible Life Insurance benefit in effect for You, subject to the following:

Maximum Accelerated Benefit Amount. The maximum amount We will pay for each ABO Eligible Life Insurance benefit is shown in the SCHEDULE OF BENEFITS.

Scheduled Reduction of an ABO Eligible Life Insurance Benefit. If an ABO Eligible Life Insurance benefit is scheduled to reduce within the 12 month period after the date You or Your legal representative request an accelerated benefit, We will calculate the accelerated benefit using the amount of such ABO Eligible Life Insurance that will be in effect immediately after the reduction(s) scheduled for such period.

Scheduled End of an ABO Eligible Life Insurance Benefit. If an ABO Eligible Life Insurance benefit is scheduled to end within 12 months after the date You or Your legal representative request an accelerated benefit, We will not pay an accelerated benefit for such ABO Eligible Life Insurance benefit.

Previous Conversion of an ABO Eligible Life Insurance Benefit. We will not pay an accelerated benefit for any amount of ABO Eligible Life Insurance which You previously converted under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU.

We will pay the accelerated benefit in one sum unless You or Your legal representative select another payment mode.

Effect of Payment of an Accelerated Benefit

On premium for Your Life Insurance. After We pay the accelerated benefit, any premium You are required to pay will be based upon the amount of Your Life Insurance remaining after the accelerated benefit is paid.

On Your Life Insurance at Your death. The amount of Life Insurance that We will pay at Your death will be decreased by the amount of the accelerated benefit paid by Us.

On Your Life Insurance at conversion. The amount to which You are entitled to convert under the section entitled LIFE INSURANCE: CONVERSION OPTION FOR YOU, will be decreased by the amount of the accelerated benefit paid by Us

On Your Accidental Death and Dismemberment Insurance. Payment of an accelerated benefit will not affect Your Accidental Death and Dismemberment Insurance.

Date Your Option to Accelerate Benefits Ends

The accelerated benefit option will end on the earliest of:

- the date the ABO Eligible Life Insurance ends;
- the date You or Your legal representative assign all ABO Eligible Life Insurance; or
- the date You or Your legal representative have accelerated all ABO Eligible Life Insurance benefits

LIFE INSURANCE: CONVERSION OPTION FOR YOU

If Your Life Insurance ends for any of the reasons stated below, You have the option to buy an individual policy of life insurance ("new policy") from Us during the Application Period in accordance with the conditions and requirements of this section. This is referred to as the "option to convert". Evidence of Your insurability will not be required.

When You Will Have the Option to Convert

You will have the option to convert when:

- Your Life Insurance ends because:
  - You cease to be in an eligible class;
  - Your employment ends;
  - the Group Policy ends, provided You have been insured for Life Insurance for at least 5 years; or
  - the Group Policy is amended to end Life Insurance for an eligible class of which You are a member, provided You have been insured for Life Insurance for at least 5 years

A reduction in the amount of Your Life Insurance as a result of the payment of an accelerated benefit will not give rise to a right to convert under this section.

Application Period

If You opt to convert Your Life Insurance for any of the reasons stated above, We must receive a completed conversion application form from You within the Application Period described below.

If You are given Written notice of the option to convert within 15 days before or after the date Your Life Insurance ends, the Application Period begins on the date that such Life Insurance ends and expires 31 days after such date.

If You are given Written notice of the option to convert more than 15 days after the date Your Life Insurance ends, the Application Period begins on the date such Life Insurance ends and expires 15 days from the date of such notice. In no event will the Application Period exceed 91 days from the date Your Life Insurance ends.

Option Conditions

The option to convert is subject to these conditions:

1. Our receipt within the Application Period of:
   - Your Written application for the new policy; and
   - the premium due for such new policy;
2. the premium rates for the new policy will be based on:
   - Our rates then in use;
   - the form and amount of insurance;
   - Your class of risk; and
   - Your attained age when Your Life Insurance ends;
3. the new policy may be on any form then customarily offered by Us excluding term insurance;
4. the new policy will be issued without an accidental death and dismemberment benefit, a continuation benefit, an accelerated benefit option, a waiver of premium benefit or any other rider or additional benefit; and
5. the new policy will take effect on the 32nd day after the date Your Life Insurance ends; this will be the case regardless of the duration of the Application Period

LIFE INSURANCE: CONVERSION OPTION FOR YOU (continued)

Maximum Amount of the New Policy

If Your Life Insurance ends due to the end of the Group Policy or the amendment of the Group Policy to end Life Insurance for an eligible class of which You are a member, the maximum amount of insurance that You may elect for the new policy is the lesser of:

- the amount of Your Life Insurance that ends under the Group Policy less the amount of life insurance for which You become eligible under any group policy within 31 days after the date insurance ends under the Group Policy; or
- $2,000.

If Your Life Insurance ends for any other reason the maximum amount of insurance that You may elect for the new policy is the amount of Your Life Insurance which ends under the Group Policy

If You Die Within 31 Days After Your Life Insurance Ends

If You die within 31 days after Your Life Insurance ends, Proof of Your death must be sent to Us. When We receive such Proof with the claim, We will review the claim and if We approve it will pay the Beneficiary the amount of Life Insurance You were entitled to convert

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If You sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to Us. When We receive such Proof We will review the claim and, if We approve it, will pay the insurance in effect on the date of the injury.

Direct and Sole Cause means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes

We will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

PRESUMPTION OF DEATH

You will be presumed to have died as a result of an accidental injury if:

- the aircraft or other vehicle in which You were traveling disappears, sinks, or is wrecked; and
- the body of the person who has disappeared is not found within 1 year of:
  - the date the aircraft or other vehicle was scheduled to have arrived at its destination, if traveling in an aircraft or other vehicle operated by a Common Carrier; or
  - the date the person is reported missing to the authorities, if traveling in any other aircraft or other vehicle.

EXCLUSIONS

We will not pay benefits under this section for any loss caused or contributed to by:

1. physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;
2. infection, other than infection occurring in an external accidental wound;
3. suicide or attempted suicide;
4. intentionally self-inflicted injury;
5. service in the armed forces of any country or international authority, except the United States National Guard;
6. any incident related to:
   - travel in an aircraft as a pilot, crew member, flight student or while acting in any capacity other than as a passenger;
   - travel in an aircraft for the purpose of parachuting or otherwise exiting from such aircraft while it is in flight;
   - parachuting or otherwise exiting from an aircraft while such aircraft is in flight, except for self-preservation;
   - travel in an aircraft or device used:
     - for testing or experimental purposes;
     - by or for any military authority; or
     - for travel or designed for travel beyond the earth's atmosphere;
7. committing or attempting to commit a felony;
8. the voluntary intake or use by any means of:
   - any drug, medication or sedative, unless it is:
     - taken or used as prescribed by a Physician, or
     - an "over the counter" drug, medication or sedative taken as directed;
   - alcohol in combination with any drug, medication, or sedative; or

- poison, gas, or fumes; or

9. war, whether declared or undeclared; or act of war, insurrection, rebellion or riot.

Exclusion for Intoxication

We will not pay benefits under this section for any loss if the injured party is intoxicated at the time of the incident and is the operator of a vehicle or other device involved in the incident.

Intoxicated means that the injured person's blood alcohol level met or exceeded the level that creates a legal presumption of intoxication under the laws of the jurisdiction in which the incident occurred.

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary.

For any other loss sustained by You We will pay benefits to You.

If You sustain more than one Covered Loss due to an accidental injury, the amount We will pay, on behalf of any such injured person, will not exceed the Full Amount.

We will pay benefits in one sum. Other modes of payment may be available upon request. For details call Our toll free number shown on the Certificate Face Page.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (continued)

ADDITIONAL BENEFIT: SEAT BELT USE

If You die as a result of an accidental injury, We will pay this additional Seat Belt Use benefit if:

1. We pay a benefit for loss of life under the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section;
2. this benefit is in effect on the date of the injury; and
3. We receive Proof that the deceased person:
   - was in an accident while driving or riding as a passenger in a Passenger Car;
   - was wearing a Seat Belt which was properly fastened at the time of the accident; and
   - died as a result of injuries sustained in the accident

A police officer investigating the accident must certify that the Seat Belt was properly fastened. A copy of such certification must be submitted to Us with the claim for benefits

Passenger Car means any validly registered four-wheel private passenger car, four-wheel drive vehicle, sports-utility vehicle, pick-up truck or mini-van. It does not include any commercially licensed car, any private car being used for commercial purposes, or any vehicle used for recreational or professional racing

Seat Belt means any restraint device that:

- meets published United States Government safety standards;
- is properly installed by the car manufacturer; and
- is not altered after the installation.

The term includes any child restraint device that meets the requirements of state law

BENEFIT AMOUNT

The Seat Belt Use benefit is an additional benefit equal to 10% of the Full Amount shown in the SCHEDULE OF BENEFITS. However, the amount We will pay for this benefit will not be less than $1,000 or more than $10,000

BENEFIT PAYMENT

For loss of Your life, We will pay benefits to Your Beneficiary

The Policyholder should have a supply of claim forms. Obtain a claim form from the Policyholder and fill it out carefully. Return the completed claim form with the required Proof to the Policyholder. The Policyholder will certify Your Insurance under the Group Policy and send the certified claim form and Proof to Us.

When We receive the claim form and Proof, We will review the claim and, if We approve it, We will pay benefits subject to the terms and provisions of this certificate and the Group Policy.

CLAIMS FOR LIFE INSURANCE BENEFITS

When a claimant files a claim for Life Insurance benefits, Proof should be sent to Us as soon as is reasonably possible after the death of an Insured.

CLAIMS FOR OTHER INSURANCE BENEFITS

When a claimant files a claim for any other Insurance benefits described in this certificate, both the notice of claim and the required Proof should be sent to Us within 90 days of the date of a loss

Notice of claim and Proof may also be given to Us by following the steps set forth below:

Step 1
A claimant may give Us notice by calling Us at the toll free number shown in the Certificate Face Page within 20 days of the date of a loss

Step 2
We will send a claim form to the claimant and explain how to complete it. The claimant should receive the claim form within 15 days of giving Us notice of claim

Step 3
When the claimant receives the claim form, the claimant should fill it out as instructed and return it with the required Proof described in the claim form

If the claimant does not receive a claim form within 15 days after giving Us notice of claim, Proof may be sent using any form sufficient to provide Us with the required Proof.

Step 4
The claimant must give Us Proof not later than 90 days after the date of loss

If notice of claim or Proof is not given within the time limits described in this section, the delay will not cause a claim to be denied or reduced if such notice and Proof are given as soon as is reasonably possible.

Time Limit on Legal Actions. A legal action on a claim may only be brought against Us during a certain period. This period begins 60 days after the date Proof is filed and ends 3 years after the date such Proof is required

GENERAL PROVISIONS

Assignment

You may assign Your Life Insurance rights and benefits under the Group Policy as a gift or as a viatical assignment as described below. You may also assign Your Accidental Death and Dismemberment Insurance rights and benefits under the Group Policy as a gift. We will recognize the assignee(s) under such assignment as owner(s) of Your right, title and interest in the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You and the assignee(s);
3. the Policyholder acknowledges that Your Life Insurance and Accidental Death and Dismemberment Insurance being assigned is in force on the life of the assignor; and
4. the Written form is delivered to Us for recording

You may have made an irrevocable assignment under a group policy that the Group Policy replaces. In this case, We will recognize the assignee(s) under such assignment as owners of Your right, title and interest under the Group Policy if:

1. a Written form satisfactory to Us, affirming this assignment, has been completed;
2. the Written form has been Signed by You, the assignee(s) and the Policyholder; and
3. the Written form is delivered to Us for recording

Beneficiary

You may designate a Beneficiary in Your application or enrollment form. You may change Your Beneficiary at any time. To do so, You must send a Signed and dated, Written request to the Policyholder using a form satisfactory to Us. Your Written request to change the Beneficiary must be sent to the Policyholder within 30 days of the date You Sign such request.

You do not need the Beneficiary's consent to make a change. When We receive the change, it will take effect as of the date You Signed it. The change will not apply to any payment made in good faith by Us before the change request was recorded.

If two or more Beneficiaries are designated and their shares are not specified, they will share the insurance equally.

If there is no Beneficiary designated or no surviving Beneficiary at Your death, We may determine the Beneficiary to be one or more of the following who survive You:

1. Your Spouse;
2. Your child(ren);
3. Your parent(s); or
4. Your sibling(s)

Instead of making payment to any of the above, we may pay Your estate. Any payment made in good faith will discharge our liability to the extent of such payment.

If a Beneficiary or a payee is a minor or incompetent to receive payment, We will pay that person's guardian.

Entire Contract

Your insurance is provided under a contract of group insurance with the Policyholder. The entire contract with the Policyholder is made up of the following:

1. the Group Policy and its Exhibits, which include the certificate(s);

2 the Policyholder's application; and

3 any amendments and/or endorsements to the Group Policy

Incontestability: Statements Made by You

Any statement made by You will be considered a representation and not a warranty We will not use such statement to contest life insurance, reduce benefits or defend a claim unless the following requirements are met:

1 the statement is in a Written application or enrollment form;

2 You have Signed the application or enrollment form; and

3 a copy of the application or enrollment form has been given to You or Your Beneficiary

We will not use Your statements which relate to insurability to contest life insurance after it has been in force for 2 years during Your life In addition. We will not use such statements to contest an increase or benefit addition to such insurance after the increase or benefit has been in force for 2 years during Your life, unless the statement is fraudulent

Misstatement of Age

If Your age is misstated, the correct age will be used to determine if insurance is in effect and, as appropriate, We will adjust the benefits and/or premiums.

Conformity with Law

If the terms and provisions of this certificate do not conform to any applicable law, this certificate shall be interpreted to so conform.

Physical Exams

If a claim is submitted for insurance benefits other than life insurance benefits, We have the right to ask the insured to be examined by a Physician(s) of Our choice as often as is reasonably necessary to process the claim. We will pay the cost of such exam

Autopsy

We have the right to make a reasonable request for an autopsy where permitted by law Any such request will set forth the reasons We are requesting the autopsy.

THIS IS THE END OF THE CERTIFICATE
THE FOLLOWING IS ADDITIONAL INFORMATION

ERISA INFORMATION

NAME AND ADDRESS OF EMPLOYER AND PLAN ADMINISTRATOR

Bridgestone Americas Holding, Inc
1200 Firestone Parkway
Akron. OH 44317-0001
330-379-4648

EMPLOYER IDENTIFICATION NUMBER: 88-0335067

PLAN NUMBER	COVERAGE	PLAN NAME
000	Basic Life and Accidental Death and Dismemberment Insurance	Bridgestone Americas Holding. Inc

TYPE OF ADMINISTRATION

The above listed benefits are insured by Metropolitan Life Insurance Company ("MetLife").

AGENT FOR SERVICE OF LEGAL PROCESS

For disputes arising under the Plan, service of legal process may be made upon the Plan administrator at the above address. For disputes arising under those portions of the Plan insured by MetLife, service of legal process may be made upon MetLife at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside

ELIGIBILITY FOR INSURANCE; DESCRIPTION OR SUMMARY OF BENEFITS

Your MetLife certificate describes the eligibility requirements for insurance provided by MetLife under the Plan It also includes a detailed description of the insurance provided by MetLife under the Plan

PLAN TERMINATION OR CHANGES

The group policy sets forth those situations in which the Employer and/or MetLife have the rights to end the policy

The Employer reserves the right to change or terminate the plan at any time Therefore, there is no guarantee that you will be eligible for the insurance described herein for the duration of your employment. Any such action will be taken only after careful consideration

Your consent or the consent of your beneficiary is not required to terminate, modify. amend, or change the Plan

In the event Your insurance ends in accord with the "Date Your Insurance Ends" subsection of Your certificate, you may still be eligible to receive benefits. The circumstances under which benefits are available are described in Your MetLife certificate.

CONTRIBUTIONS

No contribution is required for Basic Life Insurance and Accidental Death and Dismemberment Insurance

The total premium rate for insurance provided under the Plan by MetLife is set by MetLife.

PLAN YEAR

The Plan's fiscal records are kept on a Plan year basis beginning each January 1st and ending on the following December 31st

Qualified Domestic Relations Orders/Qualified Medical Child Support Orders

You and your beneficiaries can obtain, without charge, from the Plan Administrator a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and Qualified Medical Child Support Orders (QMCSO)

CLAIMS INFORMATION

Procedures for Presenting Claims for Life and Accidental Death and Dismemberment Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Employer who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims The instructions on the claim form should be followed carefully This will expedite the processing of the claim. Be sure all questions are answered fully

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the employer who is usually able to provide the necessary information.

CLAIM SUBMISSION

In submitting claims for life and accidental death and dismemberment benefits ("Benefits"), the claimant must complete the appropriate claim form and submit the required proof as described in the certificate

Claim forms must be submitted in accordance with the instructions on the claim form

Initial Determination

After MetLife receives your claim for Benefits, MetLife will review your claim and notify you of its decision to approve or deny your claim.

Such notification will be provided to you within a reasonable period, not to exceed 90 days from the date we received your claim, unless MetLife notifies you within that period that there are special circumstances requiring an extension of time of up to 90 additional days

If MetLife denies your claim in whole or in part, the notification of the claims decision will state the reason why your claim was denied and reference the specific Plan provision(s) on which the denial is based If the claim is denied because MetLife did not receive sufficient information, the claims decision will describe the additional information needed and explain why such information is needed. The notification will also include a description of the Plan review procedures and time limits, including a statement of your right to bring a civil action if your claim is denied after an appeal.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report and do not receive them within 30 days, you may file suit in a Federal court In such a case, the court may require the Plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator If you have a claim for benefits which is denied or ignored. in whole or in part, you may file suit in a state or Federal court.

In addition. if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor. or you may file suit in a Federal court

The court will decide who should pay court costs and legal fees. If you are successful. the court may order the person you have sued to pay these costs and fees

If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U S Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S Department of Labor, 200 Constitution Avenue N W , Washington, D.C 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration

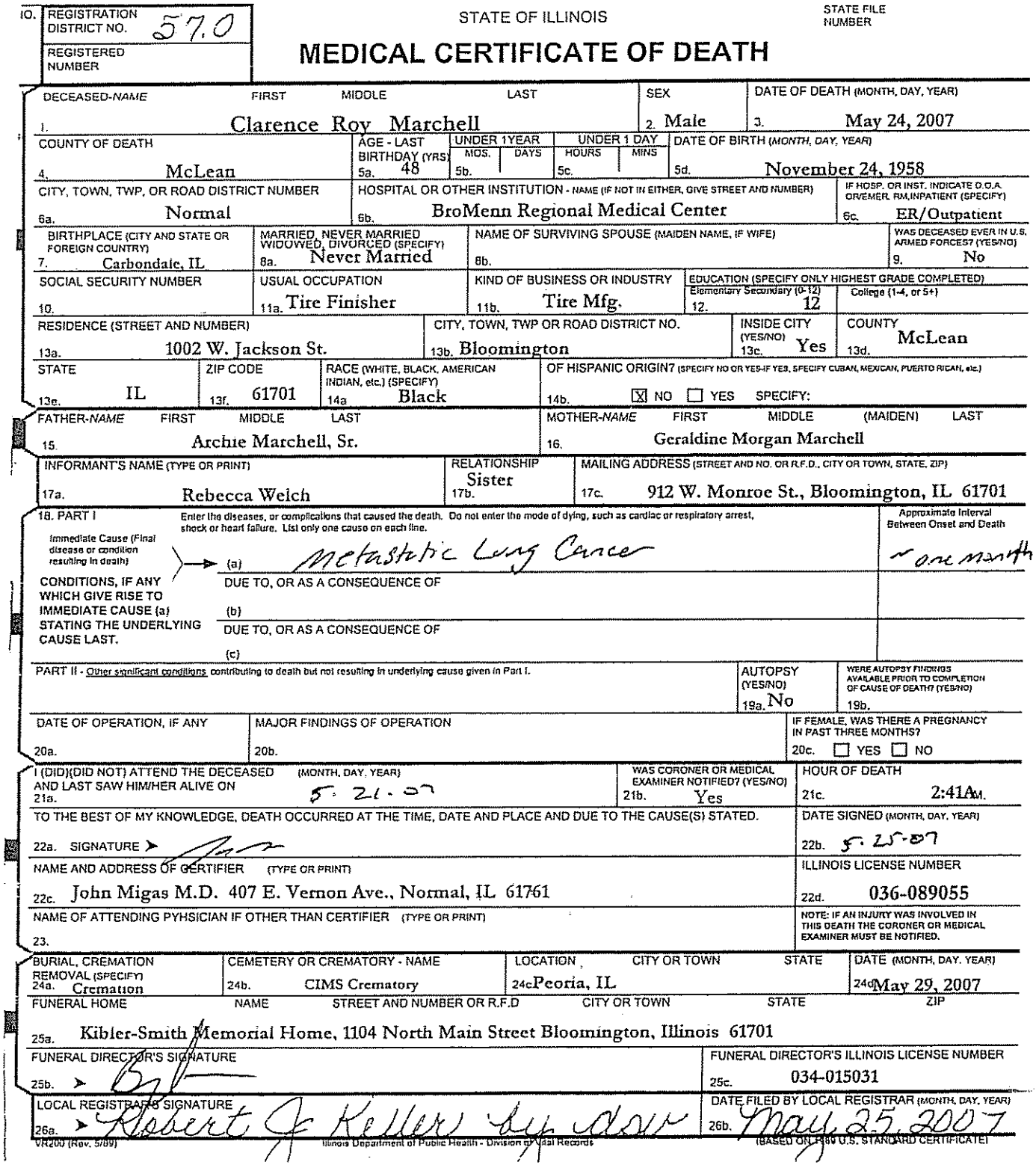
FUTURE OF THE PLAN

It is hoped that the Plan will be continued indefinitely, but Bridgestone Americas Holding, Inc. reserves the right to change or terminate the Plan in the future Any such action would be taken only after careful consideration.

The Board of Directors of Bridgestone Americas Holding, Inc shall be empowered to amend or terminate the Plan or any benefit under the Plan at any time.

08CV3336
JUDGE KOCORAS
MAGISTRATE JUDGE BROWN
TG

EXHIBIT B



STATE OF ILLINOIS

STATE FILE NUMBER

MEDICAL CERTIFICATE OF DEATH

10. REGISTRATION DISTRICT NO. 57.0

REGISTERED NUMBER

1. DECEASED-NAME (FIRST, MIDDLE, LAST): Clarence Roy Marchell
2. SEX: Male
3. DATE OF DEATH (MONTH, DAY, YEAR): May 24, 2007
4. COUNTY OF DEATH: McLean
5a. AGE - LAST BIRTHDAY (YRS): 48
5b. UNDER 1 YEAR - MOS. / DAYS
5c. UNDER 1 DAY - HOURS / MINS
5d. DATE OF BIRTH (MONTH, DAY, YEAR): November 24, 1958
6a. CITY, TOWN, TWP, OR ROAD DISTRICT NUMBER: Normal
6b. HOSPITAL OR OTHER INSTITUTION - NAME (IF NOT IN EITHER, GIVE STREET AND NUMBER): BroMenn Regional Medical Center
6c. IF HOSP. OR INST. INDICATE O.D.A. OR/EMER. RM./INPATIENT (SPECIFY): ER/Outpatient
7. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY): Carbondale, IL
8a. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPECIFY): Never Married
8b. NAME OF SURVIVING SPOUSE (MAIDEN NAME, IF WIFE):
9. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO): No
10. SOCIAL SECURITY NUMBER:
11a. USUAL OCCUPATION: Tire Finisher
11b. KIND OF BUSINESS OR INDUSTRY: Tire Mfg.
12. EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) - Elementary/Secondary (0-12): 12 - College (1-4, or 5+):
13a. RESIDENCE (STREET AND NUMBER): 1002 W. Jackson St.
13b. CITY, TOWN, TWP OR ROAD DISTRICT NO.: Bloomington
13c. INSIDE CITY (YES/NO): Yes
13d. COUNTY: McLean
13e. STATE: IL
13f. ZIP CODE: 61701
14a. RACE (WHITE, BLACK, AMERICAN INDIAN, etc.) (SPECIFY): Black
14b. OF HISPANIC ORIGIN? (SPECIFY NO OR YES-IF YES, SPECIFY CUBAN, MEXICAN, PUERTO RICAN, etc.): [X] NO [ ] YES SPECIFY:
15. FATHER-NAME (FIRST, MIDDLE, LAST): Archie Marchell, Sr.
16. MOTHER-NAME (FIRST, MIDDLE, (MAIDEN), LAST): Geraldine Morgan Marchell
17a. INFORMANT'S NAME (TYPE OR PRINT): Rebecca Welch
17b. RELATIONSHIP: Sister
17c. MAILING ADDRESS (STREET AND NO. OR R.F.D., CITY OR TOWN, STATE, ZIP): 912 W. Monroe St., Bloomington, IL 61701

18. PART I — Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): (a) Metastatic Lung Cancer — Approximate Interval Between Onset and Death: one month

CONDITIONS, IF ANY WHICH GIVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART II - Other significant conditions contributing to death but not resulting in underlying cause given in Part I.

19a. AUTOPSY (YES/NO): No
19b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (YES/NO):

20a. DATE OF OPERATION, IF ANY:
20b. MAJOR FINDINGS OF OPERATION:
20c. IF FEMALE, WAS THERE A PREGNANCY IN PAST THREE MONTHS? [ ] YES [ ] NO

21a. I (DID)(DID NOT) ATTEND THE DECEASED AND LAST SAW HIM/HER ALIVE ON (MONTH, DAY, YEAR): 5-21-07
21b. WAS CORONER OR MEDICAL EXAMINER NOTIFIED? (YES/NO): Yes
21c. HOUR OF DEATH: 2:41 AM

TO THE BEST OF MY KNOWLEDGE, DEATH OCCURRED AT THE TIME, DATE AND PLACE AND DUE TO THE CAUSE(S) STATED.

22a. SIGNATURE: [signature]
22b. DATE SIGNED (MONTH, DAY, YEAR): 5-25-07
22c. NAME AND ADDRESS OF CERTIFIER (TYPE OR PRINT): John Migas M.D. 407 E. Vernon Ave., Normal, IL 61761
22d. ILLINOIS LICENSE NUMBER: 036-089055

23. NAME OF ATTENDING PYHSICIAN IF OTHER THAN CERTIFIER (TYPE OR PRINT):

NOTE: IF AN INJURY WAS INVOLVED IN THIS DEATH THE CORONER OR MEDICAL EXAMINER MUST BE NOTIFIED.

24a. BURIAL, CREMATION, REMOVAL (SPECIFY): Cremation
24b. CEMETERY OR CREMATORY - NAME: CIMS Crematory
24c. LOCATION - CITY OR TOWN, STATE: Peoria, IL
24d. DATE (MONTH, DAY, YEAR): May 29, 2007

25a. FUNERAL HOME - NAME, STREET AND NUMBER OR R.F.D, CITY OR TOWN, STATE, ZIP: Kibler-Smith Memorial Home, 1104 North Main Street Bloomington, Illinois 61701

25b. FUNERAL DIRECTOR'S SIGNATURE: [signature]
25c. FUNERAL DIRECTOR'S ILLINOIS LICENSE NUMBER: 034-015031

26a. LOCAL REGISTRAR'S SIGNATURE: Robert J. Keller by dsw
26b. DATE FILED BY LOCAL REGISTRAR (MONTH, DAY, YEAR): May 25, 2007

VR200 (Rev. 5/89) — Illinois Department of Public Health - Division of Vital Records — (BASED ON 1989 U.S. STANDARD CERTIFICATE)

I HEREBY CERTIFY that the foregoing is a true and correct copy of the DEATH record for the decedent named at Item 1, and that this record was established and filed in my office in accordance with the provisions of the Illinois Vital Records Act.

DATE May 29, 2007 SIGNED Robert J. Keller

at *Bloomington, Illinois.* Official Title *Local Registrar*

Registrar District #57.0
Bloomington IL 61701

JUDGE KOCORAS
MAGISTRATE JUDGE BROWN
TG

EXHIBIT C

BENEFITS ELIG.

BRIDGESTONE/FIRESTONE, INC.
Benefits Administration Dept.
1200 Firestone Parkway
Akron, Ohio 44317

Please print clearly.
☐ New ☒ Change

11-1-2007
Effective Date of Change

BENEFITS ENROLLMENT/CHANGE FORM FOR PLANT BARGAINING

See back of copy #3 for instructions.

Member may retain last copy. Completed forms are to be sent to Your Human Resource or Location Manager or Benefits Representative

For Office Use Only

A. MEMBER DATA: ☐ ACTIVE EMPLOYEE

NAME (Last, First, Middle)	SOCIAL SECURITY NO	DATE OF BIRTH	SERVICE DATE
Marshall, Laurence R.		11-24-58	9/26/94

ADDRESS (Street, City, State, Zip Code): 1002 W. Jackson St. Bloomington, IL 61701

WORK LOCATION	CLOCK CARD NO	☐ SALARY ☒ HOURLY	SEX ☒ M ☐ F	MARITAL STATUS ☐ MARRIED ☒ SINGLE	BUSINESS PHONE / HOME PHONE
Normal IL	11481				309 451-2325 / 309 827-8[illegible]

SPOUSE'S NAME (Last, First, Middle)	SPOUSE'S DATE BIRTH	SPOUSE'S SOCIAL SECURITY NUMBER
N/A		

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME OF SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER ADDRESS

Are you covered under your spouse's or any other group medical plan? ☐ Yes ☒ No. If yes, does your spouse have dependent coverage? ☐ Yes ☐ No

B. BENEFICIARY FOR BASIC LIFE INSURANCE, ACCIDENTAL DEATH, AND DISMEMBERMENT INSURANCE

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER
Smith	Robyn	R	1-19-67	Fiance	

C. MEDICAL INSURANCE

☒ EMPLOYEE ONLY ☐ FAMILY COVERAGE ☐ CANCEL THIS COVERAGE

☐ Comprehensive Medical Expense Benefits Plan (out-of-area plan and Medicare eligible)
☐ Point of Service Plan (POS) _____
☐ Exclusive Provider Organization (EPO) _____
☐ Health Maintenance Organization (HMO) _____
☒ Preferred Provider Organization (PPO) BC/BS of Illinois
☐ No Medical Coverage (explain) _____

PROCESSED
NOV 1[illegible]

Note: The location of Managed Care Plans is printed on the front cover of the Provider Directory.

D. DENTAL INSURANCE

☒ EMPLOYEE ONLY
☐ FAMILY COVERAGE
☐ CANCEL THIS COVERAGE
☒ DELTA Dental
☐ No Dental Coverage (give reason)

E. DEPENDENT DATA - List dependents below *only* if you want dependent coverage. IF MAKING CHANGE, LIST ONLY THAT DEPENDENT.

Please attach the required documentation to verify the eligibility of your dependents. See back of copy #1 for requirements.

☐ ADD DEPENDENT ONLY ☐ CANCEL DEPENDENT ONLY

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MO/DAY/YR)	SEX M/F	RELATIONSHIP	CHECK KIND OF CHANGE ADD	CHECK KIND OF CHANGE DELETE	SELECT A HEALTH CARE CENTER OR PRIMARY CARE PHYSICIAN FOR EACH DEPENDENT IF IN EPO, POS, OR HMO PHYSICIAN I.D. NUMBER
SPOUSE SS#	U.A. TOUGHAVE						☐	☐	
CHILD SS#							☐	☐	
CHILD SS#							☐	☐	
CHILD SS#							☐	☐	
CHILD SS#							☐	☐	
CHILD SS#							☐	☐	

IF DELETING ABOVE, GIVE REASON AND EFFECTIVE DATE.

F. REIMBURSEMENT ACCOUNT - INDICATE THE AMOUNT OF DOLLARS YOU WANT TO CONTRIBUTE EACH MONTH.

☐ SUPPLEMENTAL HEALTH CARE EXPENSE ACCOUNT UP TO $250 A MONTH $_____ Enter Amount

☒ NO SUPPLEMENTAL HEALTH CARE EXPENSE ACCOUNT.

G. ENROLLMENT IN THE 401(K) SAVINGS PLAN AND GROUP UNIVERSAL LIFE INSURANCE REQUIRES SEPARATE ENROLLMENT FORMS.

AUTHORIZATION

I hereby authorize any Provider, Insurance Company, or Employer, to release any information about me or my dependents to the Plan Administrator, Plan Sponsor, or government agency or authorized agent for the purpose of validating, determining or auditing benefits payable in connection with these Plans. I understand that payments will be made directly to the Participating Provider if I am enrolled in the EPO, POS, or HMO Plan. When I accept the coverage provided by my employer's group Medical and/or Dental Plan, I authorize my employer to reduce my taxable earnings in an amount equal to the required employee contributions toward the cost of the coverage. I understand that this also constitutes an election to participate in the Health Care Expense Account Plan. I understand that I may not change my elections until the end of the plan year except as the programs provide. I understand that any accounts remaining in a reimbursement account after reimbursement for eligible expenses incurred during the plan year will be forfeited according to Federal law. Reimbursement accounts will be changed on an annual basis but all other benefits will be in effect until a change is made by me (employee). If I am receiving a monthly pension, I authorize the Company to make deductions from my pension payment in an amount equal to the required contributions toward the cost of the coverage. If I am not receiving pay, I agree to remit the required contribution directly to the Company. If I choose no medical or dental benefits, I understand that evidence of good health and/or a waiting period may be required if I later wish to enroll. A photocopy of this authorization shall be considered as effective and valid as the original. I certify that this foregoing information is true and correct. I am aware that the Company reserves the right at anytime to alter, suspend, discontinue or terminate these Plans.

Employee/Member Signature: Laurence Marshall Date: 11-9-2000

039-01798 4/99

COPY #1 AND COPY #2 - SEND TO BRIDGESTONE/FIRESTONE, INC.; COPY #3 - FOR YOUR FILES, KEEP IN A SAFE PLACE.

EXHIBIT D

BRIDGESTONE AMERICAS HOLDING, INC
Benefits Administration Dept.
1200 Firestone Parkway
Akron, Ohio 44317

Please print clearly.
☐ New ☒ Change

5-23-07
Effective Date of Change

BENEFITS ENROLLMENT/CHANGE FORM FOR PLANI BARGAINING

See back of copy #3 for instructions.

Member may retain last copy. Completed forms are to be sent to Your Human Resource or Location Manager or Benefits Representative

For Office Use Only

A. MEMBER DATA: ☐ ACTIVE EMPLOYEE ☐ RETIREE ☐ SURVIVING SPOUSE

NAME (Last, First, Middle)	MEMBER SOCIAL SECURITY NO. or UNIVERSAL ID NO.	DATE OF BIRTH	SERVICE DATE
Marshell Clarence		11-24-58	9-26-94

ADDRESS (Street, City, State, Zip Code): 1008 W Jackson Bloomington IL 61701

WORK LOCATION	CLOCK CARD NO.	☐ HOURLY	SEX ☒ M ☐ F	MARITAL STATUS ☐ MARRIED ☐ SINGLE	BUSINESS PHONE / HOME PHONE
Blm	11481				309 451-2408 / 309 822-8295

SPOUSE'S NAME (Last, First, Middle)	SPOUSE'S DATE BIRTH	SPOUSE'S SOCIAL SECURITY NUMBER

IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO	NAME OF SPOUSE'S EMPLOYER	SPOUSE'S EMPLOYER ADDRESS

Are you covered under your spouse's or any other group medical plan? ☐ Yes ☐ No. If yes, does your spouse have dependent coverage? ☐ Yes ☐ No

BENEFICIARY FOR BASIC LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
(See back of form for instructions.)

PRIMARY BENEFICIARY

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER
Marshell	Clarence Marshell				

SECONDARY BENEFICIARY (If PRIMARY BENEFICIARY is deceased)

LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY NUMBER

C. MEDICAL INSURANCE

☐ Healthy Directions Comprehensive Medical Plan (CMP) (out-of-area plan and Medicare eligible)
☐ CIGNA Point of Service Plan (POS)
Physician I.D. Number
☐ Preferred Provider Organization (Standard PPO)
☐ I do not wish to enroll in Medical Coverage (give reason)
☐ Cancel Coverage (give reason)
Note: ~~Please see HR Manager or Benefits Representative for the location name of your Plan.~~

D. DENTAL INSURANCE

☐ I WISH TO ENROLL IN DENTAL COVERAGE
☐ I DO NOT WISH TO ENROLL IN DENTAL COVERAGE (GIVE REASON)
☐ CANCEL COVERAGE (GIVE REASON)

E. DEPENDENT DATA - List dependents below *only* if you want dependent coverage. IF MAKING CHANGE, LIST ONLY THAT DEPENDENT
Please attach the required documentation to verify the eligibility of your dependents. See back of copy #1 of this form for requirements.
☐ ADD DEPENDENT ONLY ☐ CANCEL DEPENDENT ONLY

SOCIAL SECURITY NUMBER	LAST NAME	FIRST NAME	M.I.	DATE OF BIRTH (MO/DAY/YR)	SEX M/F	RELATIONSHIP	CHECK KIND OF CHANGE: Add	CHECK KIND OF CHANGE: Delete	PLAN ELECTION: Medical	PLAN ELECTION: Dental	PHYSICIAN I.D. NUMBER
SPOUSE SS#							☐	☐	☐	☐	
CHILD SS#							☐	☐	☐	☐	
CHILD SS#							☐	☐	☐	☐	
CHILD SS#							☐	☐	☐	☐	
CHILD SS#							☐	☐	☐	☐	
CHILD SS#							☐	☐	☐	☐	

*IF DELETING ABOVE, GIVE REASON AND EFFECTIVE DATE.

F. REIMBURSEMENT ACCOUNT - INDICATE THE AMOUNT OF DOLLARS YOU WANT TO CONTRIBUTE EACH MONTH.

☐ SUPPLEMENTAL HEALTH CARE EXPENSE ACCOUNT UP TO $416.66 A MONTH
Enter Amount $ _____
☐ NO SUPPLEMENTAL HEALTH CARE EXPENSE ACCOUNT.

G. ENROLLMENT IN THE 401(K) SAVINGS PLAN AND OPTIONAL LIFE INSURANCE REQUIRES SEPARATE ENROLLMENT FORMS.

MetLife
JUN 05 2007
GLI-U-43

AUTHORIZATION

I hereby authorize any Provider, Insurance Company, or Employer, to release any information about me or my dependents to the Plan Administrator, Plan Sponsor, or government agency or authorized agent for the purpose of validating, determining or auditing benefits payable in connection with these Plans. I understand that payments will be made directly to the Participating Provider if I am enrolled in the POS or PPO Plan. When I accept the coverage provided by my employer's group Medical and/or Dental Plan, I authorize my employer to reduce my taxable earnings in an amount equal to the required employee contributions toward the cost of the coverage. I understand that this also constitutes an election to participate in the Health Care Expense Account Plan. I understand that I may not change my elections until the end of the plan year except as the programs provide. I understand that any accounts remaining in a reimbursement account after reimbursement for eligible expenses incurred during the plan year will be forfeited according to Federal law. Reimbursement accounts will be changed on an annual basis but all other benefits will be in effect until a change is made by me (employee). If I am receiving a monthly pension, I authorize the Company to make deductions from my pension payment in an amount equal to the required contributions toward the cost of the coverage. If I am not receiving a pay, I agree to remit the required contribution directly to the Company. If I choose no medical or dental benefits, I understand that evidence of good health and/or a waiting period may be required if I later wish to enroll. A photocopy of this authorization shall be considered as effective and valid as the original. I certify that this foregoing information is true and correct. I am aware that the Company reserves the right at anytime to alter, suspend, discontinue or terminate these Plans.

Employee/Member Signature: Clarence L. Marshell Date: 5-23-07

049-01795 DRAFT REV. 2006

COPY #1 AND COPY #2 - SEND TO BRIDGESTONE/FIRESTONE, INC.; COPY #3 - FOR YOUR FILES, KEEP IN A SAFE PLACE

08CV3336
JUDGE KOCORAS
MAGISTRATE JUDGE BROWN
TG

EXHIBIT E

JOHN W. YODER LAW FIRM

ATTORNEYS AT LAW
306 EAST GROVE STREET
BLOOMINGTON, ILLINOIS 61701

JOHN WM. YODER
LEE ANN S. HILL
BRENDA TEMKE

Of Counsel
JOHN W. YODER

TELEPHONE
309-829-3344

FAX
309-828-4496

June 15, 2007

MetLife
Group Life Claims
5950 Airport Rd
Oriskany, NY 13424

RE: Deceased Name: Clarence R. Marchell
Date of Death: May 24, 2007
SS#
Employer: Bridgestone Tire

Dear Sir or Madam:

Please be advised that this office represents Robyn Smith, who I understand to be named as beneficiary on one life insurance policy for the above named, Clarence Marchell who passed away May 24, 2007. Ms. Smith believes that she had been named on two MetLife insurance policies insuring Mr. Marchell's life, however, a change of beneficiary form for one policy was executed shortly prior to Mr. Marchell death.

I am writing to advise you that for several days prior to his death on May 24th, Mr. Marchell may have been of unsound mind, lacking the capacity to understand the purpose and affect of the change of beneficiary form, signed by him at that time. As such, it is our contention that the change of beneficiary form executed shortly before Mr. Marchell's death is not valid and should not be considered effective in changing the prior beneficiary designation of Robyn Smith.

Please consider this letter demand that the change of beneficiary form executed shortly before May 24, 2007, for the MetLife Policy on Mr. Marchell be found to be ineffective. The policy owner lacked sufficient capacity to understand the purpose of the form and failed to properly complete the same. The policy benefits should not be distributed until such time as this matter can be determined by court proceedings here in McLean County, Illinois.

Should you have any questions or concerns, please feel free to contact me.

Very truly yours,

John Wm. Yoder

JWmY:sjh